was also a prognostic indicator for the OS (HR=2.48, p=0.035) in HCC after resection.
Conclusions: Liver function prior to surgery and poor tumour differentiation are prognostic factors for OS and PFS after resection.

0871: LAPAROSCOPIC SUBTOTAL CHOLECYSTECTOMY WITHOUT CYSTIC DUCT LIGATION – AN ALTERNATIVE TO OPEN CONVERSION. A PROSPECTIVE STUDY

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Introduction: Laparoscopic cholecystectomy is the gold standard in the treatment of symptomatic gallstones. The dissection of the calot's triangle can be complicated by acute or chronic inflammation. Laparoscopic subtotal cholecystectomy can be an alternative to open conversion for these difficult cases.
Methods: Prospective study of laparoscopic subtotal cholecystectomies performed by a single surgeon in a teaching hospital from 2007 - 2011. Total 179 cholecystectomies were performed, 162 were laparoscopic, 6 were open conversions, 1 open and 10 laparoscopic subtotal. 104 were elective and 58 were emergency.
Results: Ten laparoscopic subtotal cholecystectomies without cystic duct ligation were performed. Median age was 65 years (range 52-84 years). Median duration of hospital stay was 7 days (range 7-40 days). 7 were emergency and 3 were elective. Operative findings included empyema in 4, chronic cholecystitis in 2, acute in 3 and perforated gall bladder in 1. All patients had an intra-abdominal drain placement. Bile leak occurred in two patients, one settled spontaneously in 8 days and the other was managed with an endoscopic retrograde cholangiopancreatography and stent. No other complications were reported.
Conclusion: Laparoscopic subtotal cholecystectomy is an alternative to open conversion in difficult cases. Bile leak can occur but can be easily managed.

0983: ROUTINE COAGULATION SCREENING IS AN UNNECESSARY STEP IN PATIENTS WITHOUT EVIDENCE OF BIOCHEMICAL JAUNDICE PRIOR TO ERCP

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Aims: UK guidelines recommend that patients undergoing endoscopic retrograde cholangio-pancreatography (ERCP) should undergo coagulation screening within 72 hours of the procedure. We hypothesised that coagulation is rarely deranged without biochemical jaundice, making coagulation screening unnecessary.
Methods: All ERCP procedures performed at our tertiary referral centre between June 2011 and September 2012 were analysed. Demographics, pre-procedure prothrombin time (PT), bilirubin levels, indications and procedures performed were recorded. 519 procedures were included, with 55 patients excluded due to incomplete records or anti-coagulation therapy.
Results: The cohort was divided into two groups: jaundiced (n=266) (elevated pre-procedure bilirubin) and non-jaundiced (n=253) (normal pre-procedure bilirubin). In the jaundiced group 6% had a significantly prolonged PT (international normalised ratio (INR) of≥1.5). In the non-jaundiced group none had an INR≥1.5, 6% had a mildly raised PT (INR=1<x<1.5), with no bleeding complications. The PT between the jaundiced and non-jaundiced groups was significantly different (mean ±confidence interval; 12.9±0.65 vs. 11.1±0.14; p<0.001).
Conclusions: Our data suggests that patients with normal bilirubin levels pre-ERCP rarely have deranged coagulation. In patients with a negative bleeding history and normal liver function tests undergoing ERCP, we suggest that coagulation screening is unnecessary. Focused coagulation testing could represent an annual saving of over £370,000 nationally.

1034: COMMON BILE DUCT – DOES SIZE MATTER?

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Aims: To evaluate correlation between pre- and intraoperative common bile duct (CBD) measurements and incidence of CBD stones at the routine intraoperative cholangiogram(IOC).
Methods: Retrospective review of patients undergoing laparoscopic cholecystectomy with routine IOC at Wexham Park Hospital between Jan 2007-Jan 2010. CBD size at pre-operative imaging (USS, CT and/or MRCP) and IOC were analysed alongside with incidence of CBD calculi.
Results: 78 patients underwent IOC. In 21(Group 1), CBD size was measured preoperatively at 4-15mm(mean 8mm) whereas intraoperative CBD size ranged between 6-23mm(mean 11mm). CBD calculi were seen in 7 cases preoperatively. 1 patient whose CBD measured 6mm preoperatively had a 6mm stone present at IOC. 2 patients with CBD of 11mm and 14mm preoperatively had intraoperative CBD of 20 and 18mm respectively with no calculi. In 57 patients (Group 2), preoperative CBD was reported as normal on USS but the size was not specified. On IOC, CBD size was 3-14mm(mean 6.8mm) with abnormalities not detected on pre-operative USS in 4 cases (1 CBD stone, 1 stricture, no flow to duodenum in 2 cases).
Conclusions: There is poor correlation between CBD size measured pre- and intraoperatively. It is difficult to predict presence of CBD calculi at the time of operation based on pre-operative imaging.

1214: TIMING OF CHOLECYSTECTOMY FOLLOWING ACUTE ADMISSION WITH CHOLELITHIASIS

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Aim: There is increasing evidence supporting early over delayed cholecystectomy for acute cholelithiasis. This study aims to identify factors that could predict those who may benefit from early cholecystectomy.
Method: A retrospective review of a prospectively maintained database of emergency surgical admissions at a single centre was undertaken. Admissions for acute cholelithiasis were identified over 6 months and followed-up for 6 months. Data on patient demographics, admission details, investigations, interventions and re-admissions were collected.
Results: 82 patients were identified (24(29.3%) male, median age 56(range 18-91)). 46(56.1%) patients had biliary colic, 33(40.2%) cholecystitis and 3(3.7%) cholangitis. 60(73%) patients had a cholecystectomy; 37(62%) on a separate planned admission, 20(33%) during index admission, 3(5%) at a subsequent emergency admission. No significant difference in post-operative complications was seen between the groups. 19(23%) patients were re-admitted with acute cholelithiasis within 6 months. There were no re-admissions following cholecystectomy at index admission (p=0.004). Multiple logistic regression demonstrated no statistically significant effects on the rate of in-patient cholecystectomy or re-admission when adjusted for age, gender, sepsis, deranged liver function tests, investigations or cholecystitis. (Chi square=15.6614;df=9;p=0.0743 and Chi square=8.6635;df=8;p=0.3715 respectively).
Conclusion: Early cholecystectomy for cholelithiasis is safe, effective and significant reduces the rate of re-admission with biliary complaints.

1219: RADIOFREQUENCY ABLATION FOR COLORECTAL LIVER METASTASES – A META-ANALYSIS

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Aims: The aim of the meta-analysis is to evaluate the comparative therapeutic efficacy of radiofrequency ablation (RFA) and hepatic resection (HR) for solitary colorectal liver metastases (CLM) and test whether RFA is superior compared to HR when it comes to survival (overall and disease free) and recurrence.
Methods: All studies citing the MeSH terms, "ablation" and "colorectal liver metastasis" were identified by searching the Medline database between March 2006 and March 2012. The outcome measures were the HRs and 95% CIs for the disease free survival and overall survival as well as the follow up period.
Results: From the 8 eligible studies overall survival and disease free survival are in favor of HR and this is statistically significant (p-value = 0.0002 and <0.001 respectively). The risk of recurrence following RFA is 3.54 times greater compared to the one following hepatic resection.
Conclusions: Liver resection remains the best treatment option for solitary resectable CLM - it is associated with acceptable morbidity providing adequate patient selection. In contrast, RFA is associated with significant risk of local recurrence which generally translates into decreased survival compared to resection. Currently, RFA cannot be considered a valuable alternative to liver resection in case of resectable CLM.